The Commonwealth of Virginia

Department of Medical Assistance Services

Division of Long-Term Care and Quality Assurance

Annual Report

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A Message from the Director of the Division of Long-Term Care and Quality Assurance Terry A. Smith

The Medicaid Program is the largest health care financing program for the elderly and persons with disabilities in the country. Virginia Medicaid provided funding for approximately 833,000 recipients at a cost of $4.4 billion in FY 2005; of these, 87,000 (11 percent) were elderly persons, and 163,000 (20 percent) were persons who have a disability.

Every action that we take is intended to have a positive impact on the lives of those we serve.

The Virginia Medicaid Program is managed by the Department of Medical Assistance Services (DMAS), one of eleven agencies within the Health and Human Services Secretariat, led by The Honorable Secretary of Health and Human Resources Marilyn B. Tavenner, DMAS Director Patrick W. Finnerty, Chief Deputy Director Cindi B. Jones, and Deputy Director Cheryl Roberts. DMAS has 14 separate divisions: Internal Audit, Human Resources, Maternal and Child Health, Communications and Legislative Affairs, Policy and Research, Long-Term Care and Quality Assurance, Program Operations, Health Care Services, Program Integrity, Fiscal and Purchases, Information Management, Budget and Contract Management, Provider Reimbursement, and Appeals.

The Department is committed to providing the highest quality of customer services to recipients, providers, and other stakeholders. Our goal is to provide professional commitment to our charge, teamwork amongst staff, and a promise to treat all of our recipients with dignity, integrity, and respect.

Working together, we can make a difference. We can protect those who are vulnerable, we can stabilize those who are suffering, and we can comfort those that are in need. We can make a better world for many through our services. We can, we have, and we will continue to do so. That is our commitment to the citizens of this great Commonwealth.

The Division of Long-Term Care and Quality Assurance

"To keep a lamp burning, we have to keep putting oil in it."
Mother Teresa, 1910-2003

The Division of Long-Term Care and Quality Assurance provides policy and operational support for the long-term care programs of the Department. The Division has three units:

- Facility and Home-Based Services
- Waiver Services
- Long-Term Care Policy

Facility and Home-Based Services Unit

This unit is responsible for overseeing programs and conducting quality management reviews of the providers and recipients being served in long-term care facilities and in certain home-based care programs. Oversight includes responding to policy inquiries and development of policy and procedure manuals. Staff also assists the training unit in provider training for these programs. The Facility and Home-Based Services Unit is responsible for the following programs:

- Nursing Facility
- Assisted Living Services
- Pre-Admission Screening for Nursing Facility and Assisted Living Services
- Intermediate Care Facilities for the Mentally Retarded
- Program for All-Inclusive Care of the Elderly (PACE)
- Long-Stay Hospitals
- Specialized Care
- Hospice Care
- Home Health Services
- Durable Medical Equipment and Supplies
- Rehabilitation Services (Inpatient, Outpatient, and School)
- Alzheimer's Assisted Living (AAL) Waiver

Waiver Services Unit

The Waiver Services Unit is responsible for the development, oversight, and quality management review of Virginia's Medicaid waivers. Staff responds to requests for policy interpretation, preauthorization services, and technical assistance to providers. The waivers managed by this unit are:

- Elderly or Disabled with Consumer Direction (EDCD)
- Mental Retardation (MR)
- Individual and Family Developmental Disabilities Supports (IFDDS)
- HIV/AIDS
- Technology Assisted (Tech)
- Day Support

Including the AAL Waiver managed by the Facility and Home-Based Care Unit, DMAS currently manages a total of seven waivers.

Long-Term Care Policy Unit

Long-Term Care Policy staff provides policy analysis and program development and implementation of Medicaid-funded long-term care services. The unit:

- Supports long-term care programs and have responsibility for legislative issues affecting long-term care services.
- Updates policy manuals.
- Maintains regulations related to the Division.
- Prepares applications to the Centers for Medicare and Medicaid for waivers.
- Works with the units to develop and renew waivers.
- Prepares statistical reports, manages special projects, and implements new programs as needed.

Division of LTC/QA Contact Information

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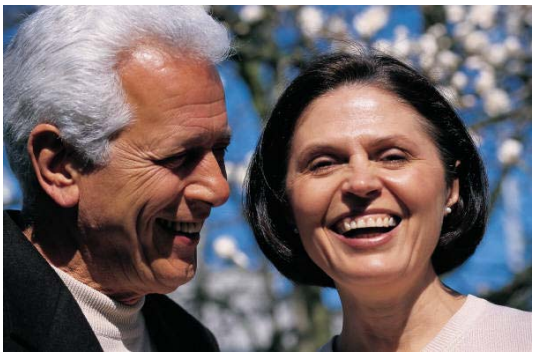
Bertha Ventura, Lead Administrative Coordinator	804-692-0481

The Division of Long-Term Care and Quality Assurance Successes

"Do all the good that you can, and make as little fuss about it as possible."
Charles Dickens



This report provides information on the services provided through DMAS for individuals in need of long-term care services. Services provided allow individuals who would otherwise face institutional placement to maintain their health, safety, and welfare in less restrictive and less costly home- and community-based programs.

While people on waivers and in institutions use other Medicaid-covered services, this report includes only those services that are long-term care in nature. Costs of those other services are reported in the aggregate to give a more complete picture of expenditures for people who receive long-term care services.

In FY 2005, the Division enjoyed the following successes:

- Creation of an Alzheimer's Assisted Living Waiver with an initial 200 slots.
- Creation of a Day Support Waiver that provides day support and prevocational services for people who are waiting for more comprehensive services.
- Planning of the expansion of the Program for All-Inclusive Care for the Elderly (PACE) to up to six areas of the Commonwealth.
- Work toward a Quality Framework and a Quality Management Strategy based on federal Centers for Medicare and Medicaid Services' (CMS) guidelines.
- Protection of the health and safety of over 19,000 waiver recipients.

Facility and Community-Based Care Services

Bill Butler, Program Manager;
Melissa Fritzman, Supervisor

If, therefore, there be any kindness I can show, or any good thing I can do to any fellow being, let me do it now, and not defer or neglect it, as I shall not pass this way again." - William Penn

Nursing Facilities

Nursing facilities (NFs) provide services to individuals in need of long-term care on a daily basis in an institutional setting. Services include 24-hour nursing supervision, social services, activities, rehabilitation, medical care, nutritional supervision, and medication administration. Began in 1969, DMAS reimburses facilities for care to individuals who meet nursing facility criteria and who are Medicaid eligible. Criteria for admission and continued stay have two components: functional capacity (the degree of assistance an individual requires completing activities of daily living (ADLs), i.e., bathing, dressing, eating, toileting, transferring, and continence) and medical or nursing needs. Nurses, physicians, nursing assistants, dietary staff, environmental services staff, social workers, and pharmacists provide services. The Virginia Department of Health licenses nursing facilities and conducts federal quality of care surveys.

238 licensed nursing facilities served 27,729 Medicaid recipients in FY 05 with expenditures of $647 million.

AGE DISTRIBUTION OF NURSING FACILITY RESIDENTS FY 2005

AGE	NUMBER	PERCENT
<21	88	<0.3
21-64	4,294	15.5
65-74	4,158	15.0
75-84	8,824	31.8
85+	10,365	37.4

Assisted Living Services

Effective August 1, 1996, the assisted living services program provides supportive medical assistance for individuals who receive an Auxiliary Grant and who are dependent in at least two ADLs. Initial admissions for services must be authorized by an approved assessor. Through DMAS, ALFs are reimbursed a per diem payment of $3/day for regular assisted living services up to a maximum of

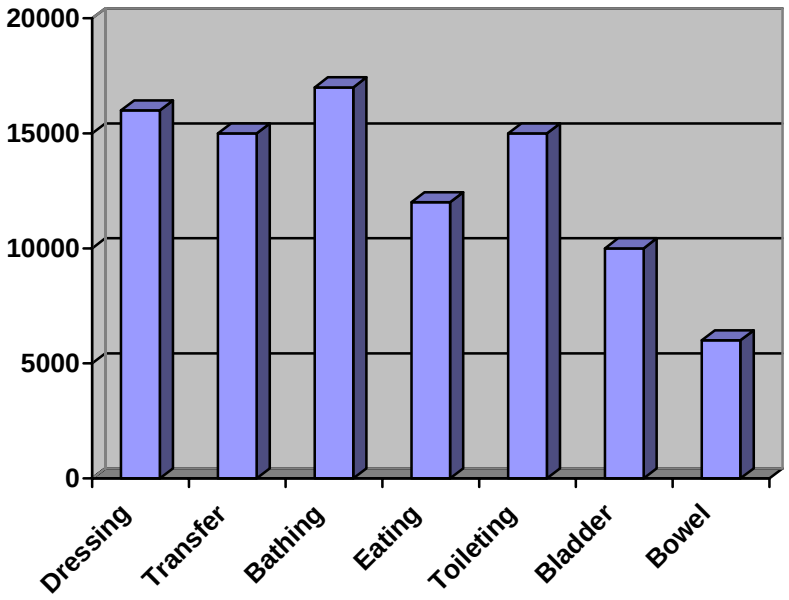
$90/month. This amount reimburses the ALF for additional medical care and services that an ALF resident may need and that is not covered under the Auxiliary Grant payment.

DMAS reimburses the ALF a per diem vendor payment of $6/day for intensive assisted living services up to a maximum of $180/month. Intensive assisted living is only available to individuals who were screened for that service prior to March 17, 2000. As of June 30, 2005, there were 219 enrolled ALFs providing services to 1,742 individuals. The cost of services was $1.7 million for regular assisted living services and slightly over $300,000 for the remaining 140 intensive assisted living recipients. The average cost per recipient was just under $1,200 per month.

Pre-Admission Screening for Nursing Facilities and Assisted Living Services

Implemented in Virginia in 1977, the pre-admission screening process is an evaluation completed to determine if a Medicaid recipient is eligible for admission to a long-term care facility or community-based waiver services, including nursing facility (NF) and assisted living facility (ALF) services. Financial resources, physical environment, functional status, social support, cognitive abilities, demographics and all medical and nursing needs are assessed. The Virginia Uniform Assessment Instrument (UAI) is the instrument used to assess individuals for publicly funded long-term care services in the Commonwealth.

Total NF Pre-Admission Screenings by ADL Dependency



For nursing facility screenings, the local departments of health and the local departments of social services perform screenings for recipients in the community. Hospital discharge planners perform screenings in hospitals. The screening teams are composed of physicians, registered nurses, social workers, and discharge planners.

In FY 05, 17,263 nursing facility/waiver pre-admission screenings were conducted using the UAI. Of those screenings:

- Close to 11,000 (61 percent) were conducted by community-based teams.
- 6,700 (39 percent) were conducted by hospital-based teams.
- 9 percent of the total individuals screened by both community-based and hospital-based teams met the criteria for entrance to a nursing facility or a waiver.

For ALFs, initial admissions for services must be assessed and authorized by a case manager employed by a public human services agency or other qualified assessors who have a contract with DMAS to completed the assessments. Reassessments are conducted at least annually and whenever there is a significant change in the individual's condition. In FY 2005, 429 ALF residential assessments were completed, and 809 ALF assisted living assessments were completed for a total of 1,238 ALF assessments conducted.

Intermediate Care Facilities for the Mentally Retarded (ICF/MR)

First covered by Medicaid in 1972, an ICF/MR is a residential setting for the diagnosis, treatment, or rehabilitation of individuals with mental retardation or related conditions. An ICF/MR must address the total needs of the resident, including physical, intellectual, social, emotional and habilitation needs, and provide active treatment. "Active treatment" consists of aggressive, structured, individualized, and professionally supervised programming based on measurable goals to help the resident function at his or her best ability.

ICFs/MR are licensed by the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services and certified by the Department of Health as an ICF/MR. Medicaid reimbursed ICFs/MR $209 million in FY 05 for services. There are 30 community-based ICFs/MR operating with a capacity to serve 317 individuals. Of these, 28 facilities serve adults only with a capacity of 201; 2 facilities serve children only with a capacity of 116.

There were close to 2,000 unduplicated residents of ICFs/MR in FY 05. Of these, approximately 150 (7 percent) were under age 21; close to 1,500 (77 percent) were between the ages of 21 and 64; and 323 (16 percent) were age 65 or older.

Program for All-Inclusive Care for the Elderly (PACE)

The Program for All-Inclusive Care for the Elderly (PACE) was established in Virginia in 1998 to provide a community-based alternative to nursing facility care integrating all aspects of care. The PACE program allows elders to remain in familiar surroundings, maintain self-sufficiency, and preserve the highest level of physical, social, and cognitive function and independence. A nursing facility preadmission screening team must authorize PACE services.

To be eligible for PACE, participants must:

- Be 55 years of age or older.
- Be screened as meeting nursing facility care criteria.
- Reside in the service area of a PACE provider.

Services include primary medical and specialty care, nursing, social services, personal care, in-home supportive services, rehabilitative therapies, meals and nutritional care, transportation, hospitalization, and nursing home care. Services are provided in a PACE center, at home, and, if needed, in the hospital or other institutional setting. Specialty and ancillary medical services are provided, as are long-term care services. The goal is to keep the elderly in the community and provide the entire continuum of medical and supportive services as needed.

Through a pre-PACE provider in the Tidewater area, 125 enrolled participants were served in FY 05 at a cost of $3.6 million for an average of approximately $29,500 per person. The program is expanding statewide in 2006.

Long-Stay Hospitals

Since 1991, long-stay hospitals provide care for individuals requiring more intensive services than is available in regular nursing facilities, but less than the degree of care and treatment provided by an acute-care hospital. The recipient must meet one of the following categories: 1) require mechanical ventilation; 2) have a communicable disease requiring universal or respiratory precautions; 3) require ongoing intravenous medication or nutrition administration; or require comprehensive rehabilitative services. Nursing facility pre-admission screening must be completed prior to admission, as well as DMAS pre-authorization.

Two long-stay hospitals have provider agreements to provide Medicaid services: Lake Taylor Hospital in Norfolk and the Hospital for Sick Children, Washington, D.C. These facilities provided services to 105 recipients in FY 05 at a cost of $12.6 million.

Specialized Care

Begun in 1991, specialized care programs respond to the need for access to care and appropriate provision of services to recipients who require more intensive resources than regular nursing facility residents, but less than a hospital. The recipient must meet one of the following categories: 1) require mechanical ventilation; 2) have a communicable disease requiring universal or respiratory precautions; 3) require ongoing intravenous medication or nutrition administration; or require comprehensive rehabilitative services. Nursing facility pre-admission screening must be completed prior to admission, as well as DMAS pre-authorization. There are different criteria for children and adults.

- Eight nursing facilities participated in the specialized care program in FY 05 serving 200 individuals.

- The program cost was close to $19 million in FY 05.

Hospice Care

Hospice services are a medically directed, interdisciplinary program for the palliative services for persons with a terminal illness and their families. The philosophy of hospice care is to help terminally ill persons remain in their homes and receive palliative rather than curative treatment. Terminally ill persons are those certified by a physician and a hospice medical director to have a life expectancy of six months or less. Medicaid began reimbursing for hospice services in 1990.

The interdisciplinary team includes core members of a physician, nurse case manager, social worker and counselors (spiritual and dietary). Home health aide services for assistance with ADLs and light homemaker services are available. Hospice can be provided in the home, an inpatient setting, or a nursing facility.

The hospice benefit covers physician services; nursing services; on-call services 24/7; home health aide and homemaker services; medical social services; medication, equipment, and supplies related to the palliation of the illness; physical, occupational, and speech/language pathology services; dietary, bereavement/

spiritual, and other counseling services; short-term inpatient care; respite care; and continuous nursing care for a short-term crisis in the home.

In FY 05, there were 63 enrolled hospice providers serving 2,238 individuals. The cost for the program was over $16 million with an average cost per recipient of $7,150.

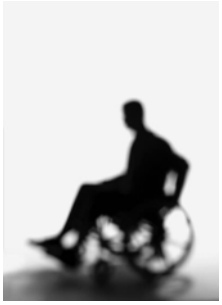
Home Health Services

Medicaid's home health services program was established in 1969. Providers must meet certification and licensure requirements as set forth by the Department of Health Professions prior to becoming a Medicaid provider. Home health services include nursing, home health aide, and physical, occupational, and speech therapies provided by a certified home health agency on a part-time or intermittent basis to a recipient in his or her place of residence. There must be medical necessity for the services in that visits must be reasonable and necessary for the diagnosis or treatment of an illness or injury or to establish a program to restore functions that have been lost or reduced by illness or injury.

In FY 05, there were 204 enrolled home health services providers serving 3,300 individuals. The cost was $4.6 million with an average cost per individual of $1,393.

Durable Medical Equipment (DME)

DME services provide equipment and supplies to recipients for the diagnosis or treatment of illness of injury or to improve the functioning of a malformed body part. DME must be ordered by a physician and be a component of the physician's plan of treatment. The program became effective in 1969.



In FY 05, there were 1,557 enrolled providers serving 77,468 individuals. The program's cost was $51.2 million with an average per recipient cost of approximately $660.

Rehabilitation Services (Inpatient, Outpatient, and School)

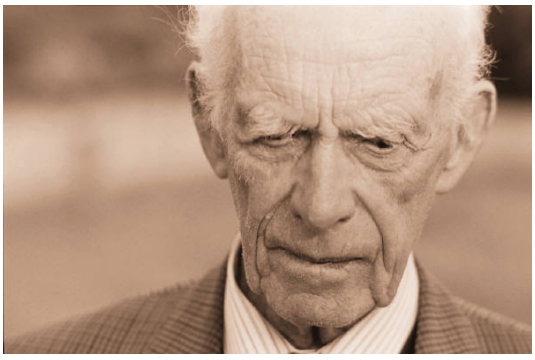
Rehabilitative services are provided to improve a recipient's ability to function as independently as possible for individuals who have lost the ability to perform ADLs due to injury or illness. Outpatient services were begun in 1978; a physician orders physical, occupational, and/or speech therapies and develops a plan of care that identifies patient goals, frequency/duration of treatment, and a discharge plan.

Medicaid began reimbursement for inpatient or outpatient intensive rehabilitation services in 1986. These services are provided to recipients who qualify for an aggressive daily interdisciplinary therapy program; in addition to physical, occupational, and/or speech therapies, cognitive rehabilitation, psychological and social work services, and therapeutic recreation services may also be provided. Intensive rehabilitation services include inpatient, Comprehensive Outpatient Rehabilitation Facility (CORF), and out-of-state. Outpatient school rehabilitation services are provided for children who do not require inpatient acute rehabilitation, but still need therapies for up to a few days per week to restore lost function. The children receive the services in the school setting and have special education needs. This program was begun in 1991 and is administered by DMAS in cooperation with the Department of Education.

REHABILITATION SERVICES FY 05

	OUTPATIENT	INPATIENT	COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY (CORF)	OUT-OF-STATE	SCHOOL
Number of Recipients Served	4,575	731	24	28	4,222
Number of Enrolled Providers	145	25	4	12	54 school districts
Total Expenditures	$7,337,385	$5,450,771	$11,303	$244,674	$3,945,164
Average Cost per Recipient	$161	$7,457	$471	$8,738	$934

Alzheimer's Assisted Living Waiver



The 2004 General Assembly mandated that DMAS develop a home- and community-based care waiver for individuals with Alzheimer's disease or a related dementia. This waiver became a reality in 2005 and will initially serve 200 individuals. Participants must reside in an assisted living facility (ALF) licensed by the Virginia Department of Social Services, be in a safe and secure environment, meet Virginia's criteria for nursing facility placement, be 55 years of age or older, and be receiving an Auxiliary Grant (AG). In order to participate in the program, the ALF must meet certain criteria. It is estimated that the waiver would be approximately $50 a day per participant.

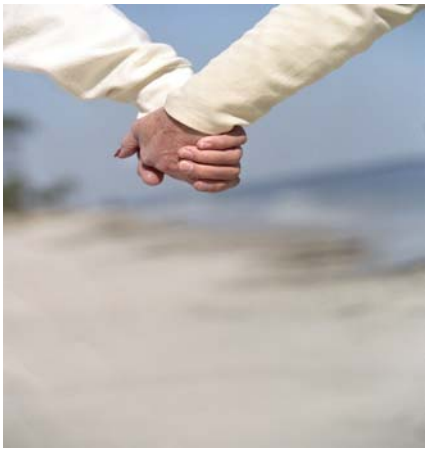
Individuals eligible to be placed on this waiver are currently either 1) remaining at home where an adult child is typically serving as primary caregiver; 2) residing in an ALF without the benefit of specialized services, which are not provided in the base $50 per day rate; or c) residing in a more expensive institutionalized nursing facility setting. Through the Alzheimer's Assisted Living Waiver, recipients would be able to receive an appropriate level of care within special care units of ALFs.

Note: Throughout this report, data are provided for the number of providers enrolled in the Medicaid Program. Not all enrolled providers actively participate.

Home- and Community-Based Waiver Services

Steve Ankiel, Program Manager
Jeff Beard and Yvonne Goodman, Supervisors

"You cannot do a kindness too soon, for you never know how soon it will be too late."
Ralph Waldo Emerson



Medicaid waivers allow states to "waive" some of the federal regulatory requirements in order to provide care in the community. Individuals must meet screening criteria for institutional placement and, if the criteria is met, they are offered a choice of institutional or community placement. Unlike many other Medicaid programs, waivers may be targeted by age and type of disability.

Congress established the Medicaid 1915(c) Home and Community-Based Care Services (HCBS) waiver program in 1981 under Section 1915(c) of the Social Security Act. This benefit offers a broad array of services, including case management, home health services, personal care, and skilled nursing assistance. Waiver services are available only to Medicaid participants who have been deemed eligible for institutional placement due to their service needs. States can target specific populations for waiver services and limit services in a waiver to a previously established number of participants or to participants living in a previously identified geographic area.

DMAS currently administers seven waivers:

- ***Elderly or Disabled with Consumer Direction (EDCD)***
- ***Mental Retardation (MR)***
- ***Individual and Family Developmental Disabilities Support (IFDDS)***
- ***HIV/AIDS***
- ***Technology Assisted (Tech)***
- ***Day Support*** *(begun 7/1/05)*
- ***Alzheimer's Assisted Living (AAL)*** *(planning begun 9/1/05; managed by Facility and Community-Based Care Unit)*

WAIVER PROGRAM DATA FY 05

Waiver	Recipients	Expenditures	Average Per Capita Expenditure
EDCD	11,904	$137,148,539	**$11,521**
HIV/AIDS	213	$783,297	**$3,677**
MR	6,421	$280,354,624	**$43,662**
IFDDS	338	$6,193,998	**$18,325**
Tech	363	$24,136,697	**$66,492**
Alzheimers*	n/a	n/a	**n/a**
Day Support*	n/a	n/a	**n/a**
TOTAL	**19,239**	**$448,617,129**	

SOURCE: CMS 372 Reports FY 2005
**New waiver in 2005.*

"The service we render others is the rent we pay for our room on earth."
Wilfred Grenfell

Top Three Diagnoses of Individuals in Waiver Programs FY 2005			
	#1	**#2**	**#3**
HIV/AIDS Waiver	Immune System Disorders	Digestive/Liver/Gall Bladder/Endocrine (Gland)	Respiratory Problems
IFDDS Waiver	Autism	Cerebral Palsy	Brain Injury
EDCD Waiver	Cardiovascular – High Blood Pressure	Digestive/Liver/Gall Bladder Problems; Diabetes	Cardiovascular – Heart Trouble
MR Waiver	Mental Retardation		
Tech Waiver	Congenital; Birth Defects	Brain Injuries	Brochopulmonary Dysphasia

WAIVER EXPENDITURES
FY 2005

SERVICE	EDCD[2]	IFDDS	MR	TECH[3]	HIV/ AIDS	SERVICE SUBTOTAL
372 Reports[1]						
Personal Care	$110,240,049	$645,426	$6,086,549	$60,650	$622,960	$117,655,634
CD Personal Care	$26					$26
Companion Care		$58,106	$79,121			$137,227
CD Facilitator Services	$122,791	$64,961	$81,279		$150	$269,181
Respite Care	$15,672,062	$38,041	$1,690,212	$570,186	$55,220	$18,025,721
Adult Day Care	$3,079,694					$3,079,694
Skilled Nursing		$37,099	$2,506,712	$23,339,435	$0	$25,883,246
PERS	$170,494	$7,200	$4,290			$181,984
Med Monitoring		$0				$0
Environmental Modifications		$179,905	$467,840	$47,575		$695,320
Assistive Technology		$164,705	$270,966	$16,039		$451,710
Congregate Residential Support			$172,930,670			$172,930,670
Day Support Services		$176,247	$51,705,345			$51,881,592
Pre-vocational Services			$2,522,996			$2,522,996
In-Home Residential Support		$1,894,497	$23,459,522			$25,354,019
Supported Employment		$53,268	$4,560,250			$4,613,518
Therapeutic Consultation		$13,975	$297,450			$311,425
Crisis Supervision		$0	$147,460			$147,460
Crisis Stabilization		$0	$73,839			$73,839
Nutritional Supplements		$0			$8,243	$8,243
Case Management (AIDS)		$0			$65,944	$65,944
Family Caregiver Training		$17,430				$17,430
SUBTOTAL	**$129,285,116**	**$3,350,860**	**$266,884,501**	**$24,033,885**	**$752,517**	**$424,306,879**

[1] *Annual Report on Home and Community-Based Waivers - Initial Reports FY 2005.*

[2] *Reflects E&D and CDPAS waivers from 7/04 through 1/05; EDCD waiver from 2/05 through 6/05.*

[3] *Statistics for the Tech Waiver are reported separately for adults and children. This column represents a sum of those categories.*

"If wrinkles must be written upon our brows, let them not be written upon the heart. The spirit should never grow old."
James A. Garfield

Elderly or Disabled with Consumer Direction (EDCD) Waiver

The EDCD Waiver got its start in Virginia in 2005, merging two existing waivers. This waiver provides services to individuals who are 65 and older or who has a disability. Eligible individuals must be eligible for care in a nursing facility.

Available services are:

- Personal Care Aide Services
- Adult Day Health Care
- Respite Care
- Personal Emergency Response System (PERS)
- Medication Monitoring
- Consumer-Directed Services

Nursing facility pre-admission screening teams conduct a pre-admission screening. A pre-authorization contractor performs pre-authorizations of services. Providers are an institution, facility, agency, partnership, corporation, or association that meets the standards and requirements set forth by DMAS and has a current, signed contract with DMAS to be a provider of waiver services.

Individual and Family Developmental Disabilities Support (IFDDS)

The IFDDS Waiver provides services to individuals 6 years of age and older with a condition related to mental retardation, but who do not have a diagnosis of mental retardation, and who have been determined to require the level of care provided in an ICF/MR. An individual is eligible for services based on three factors: diagnostic eligibility, functional eligibility, and financial eligibility.

Available services include:

- Day Support
- Supported Employment
- In-home Residential Support
- Therapeutic Consultation
- Personal Care Services
- Respite Care
- Skilled Nursing Services
- Attendant Services
- Family and Caregiver Training
- Crisis Stabilization
- Environmental Modifications
- Assistive Technology
- Personal Emergency Response System (PERS)
- Support Coordination

Mental Retardation (MR) Waiver

The waiver for individuals with mental retardation was started in Virginia in 1991. Services are available to individuals who are up to 6 years of age who are at developmental risk and individuals age 6 and older who have mental retardation. All individuals must: (1) meet the ICF/MR level of care criteria (i.e., they meet two out of seven levels of functioning in order to qualify); (2) are at imminent risk of ICF/MR placement; and (3) are determined that community-based care services under the waiver are the critical services that enable the individual to remain at home rather than being placed in an ICF/MR.

In FY 05, 6,421 participants received MR Waiver services. Total expenditures were $280 million.

MR WAIVER SERVICES AND NUMBER OF PARTICIPANTS FY 05

SERVICE	# PARTICIPANTS RECEIVING SERVICE
Day Support	4,216
Congregate Residential Support	3,420
In-home Residential Support	1,214
Pre-vocational Services	541
Respite Care	527
Supported Employment	499
Therapeutic Consultation	471
Personal Care	374
Assistive Technology	162
Environmental Modifications	129
Skilled Nursing	77
Crisis Stabilization	33
Companion Care	28
Crisis Supervision	25
Personal Emergency Response Services (PERS)	16

In addition, 485 individuals in the MR Waiver received consumer-directed personal assistance services, 757 received consumer-directed respite care, and 136 received consumer-directed companion care.

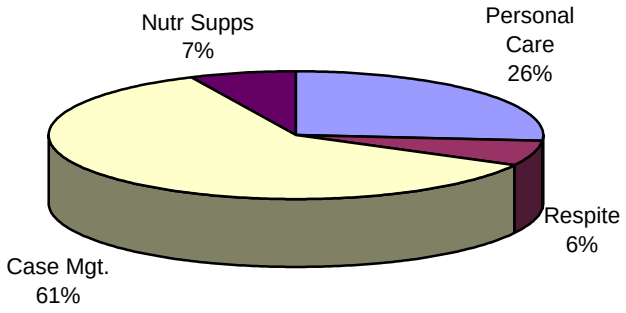
HIV/AIDS Waiver

The HIV/AIDS Waiver was developed in 1991. This waiver provides services to individuals who are diagnosed with the human immunodeficiency virus (HIV), who are experiencing the symptoms associated with acquired immune deficiency syndrome (AIDS), and who would otherwise require care provided in a nursing facility or a hospital. In FY 2005, 94 percent of individuals on the HIV/AIDS Waiver were between the ages of 21 and 65.

Available services are:

- Case management
- Nutritional supplements
- Private duty nursing
- Personal care (agency or consumer-directed options)
- Respite care (agency or consumer-directed options)

PERCENTAGE OF WAIVER COSTS BY SERVICE



Technology Assisted Waiver

The Technology Assisted Waiver was begun in 1988. This waiver is a program designed to allow eligible recipients to be cared for in the community rather than remain institutionalized. Eligible recipients are children under the age of 21, who have no third-party hospitalization insurance and are dependent on a technology to substitute for a vital body function and adults, over age 21, who currently reside in a specialized nursing facility paid for by Medicaid and who are dependent on a technology to substitute for a vital body function. All recipients must require substantial and ongoing skilled nursing services.

Available services include:

- Personal care
- Private duty nursing
- Respite care
- Environmental Modifications
- Assistive Technology

Day Support Waiver

This waiver began in 2005 as a partnership between DMAS and the Department of Mental Health, Mental Retardation and Substance Abuse Services to help reduce the MR Waiver waiting list by providing services to support families. It is in the beginning stages of implementation. Services will be available to individuals with mental retardation who have been determined to meet the level of care provided in an ICF/MR. Covered services include day support services and prevocational services. To date, there are 219 active Day Support Waiver slots.

SERVICES AND NUMBER OF PARTICIPANTS BY WAIVER FY 05

WAIVERS, Number in Waiver in FY 2005, Waiver Services	HIV/AIDS	DD	EDCD (E&D/CDPAS)	MR	Technology Assisted
Number in Waiver	213	336	11,901	6,421	363
Adult Companion Care – Agency		X		X	
Adult Companion Care – Cons. Directed		X		X	
Adult Day Health Care			X		
Assistive Technology		X		X	X
Congregate - TECH					X
Congregate Residential				X	
Environmental Modifications		X		X	X
Case Management	X			X	
Crisis Stabilization		X		X	
Day Support Regular		X		X	
Day Support High Intensity		X		X	
Family/Caregiver Training		X			
In-Home Residential		X		X	
Enteral Nutrition	X				
Medication Monitoring - Installation		X	X	X	
Medication Monitoring - Monthly		X	X	X	
Personal Care – Agency	X	X	X	X	X
Personal Care – Consumer Directed	X	X	X	X	
Personal Care - AIDS	X				
Personal Care - TECH					X
PERS Installation		X	X	X	
PERS Monitoring		X	X	X	
PERS - RN		X		X	
PERS - LPN		X		X	
Private Duty Nursing-RN	X				X
Private Duty Nursing-LPN	X				X
Respite Care - Agency (PC)	X	X	X	X	X
Respite Care - Consumer Directed	X	X	X	X	
Respite Care - AIDS	X				
Respite Care - TECH					X
Skilled Nursing –RN		X		X	
Skilled Nursing - LPN		X		X	
Supported Employment- Individual		X		X	
Supported Employment –Enclave		X		X	
Therapeutic Consultation		X		X	
Prevocational Services		X		X	
Crisis Supervision		X		X	
Waiver Costs (CMS 372 Reports)	$752,517	$3,350,862	$129,285,116	$266,884,501	$24,033,884
Waiver Costs (Offline*)	$30,780	$2,843,138	$7,863,397	$13,470,123	$102,812
Total Waiver Costs	$783,297	$6,194,000	$137,148,513	$280,354,624	$24,136,697
Total Other Costs {acute care & transportation}	$4,308,204	$3,113,397	$80,697,885	$79,968,088	$11,613,362
TOTAL COSTS (in millions)	$5,091,501	$9,307,397	$217,846,398	$360,322,712	$35,750,058

*Includes consumer-directed payroll and program operations manual payments.

A November 2005 study on the impact of an aging population on the Commonwealth was published by the Joint Legislative Audit and Review Commission (JLARC). Increases in service provision are not inevitable, but rest upon policy choices such as determining the role of the State in determining a minimum safety net of services and what minimum quality of life for older Virginians is considered to be desirable, necessary, or affordable. Certain factors, such as disability rates, availability of federal funds or caregivers, and the ability of retirees to pay for long-term care and other costs may affect the extent of demand for services.

In 1970, 11.6 percent of the state was age 60 or over. In 2000, that rate increased to 15.1 percent. It is estimated that by 2030 approximately one in four of the State's population will be 60+. In addition, by 2030, the number of persons age 85 and older is projected to double. Increases in age are typically associated with increases in disability. Eligibility for many publicly funded programs is based upon the need for assistance with ADLs. Health care costs typically increase with the number of disabilities.

Some facts about Virginia's older adult population:

- The population of Virginians age 60 and over will grow from 14.7 percent of the total population in 1990 to almost 25 percent by 2025 when there will be more than 2 million Virginians in this age group.

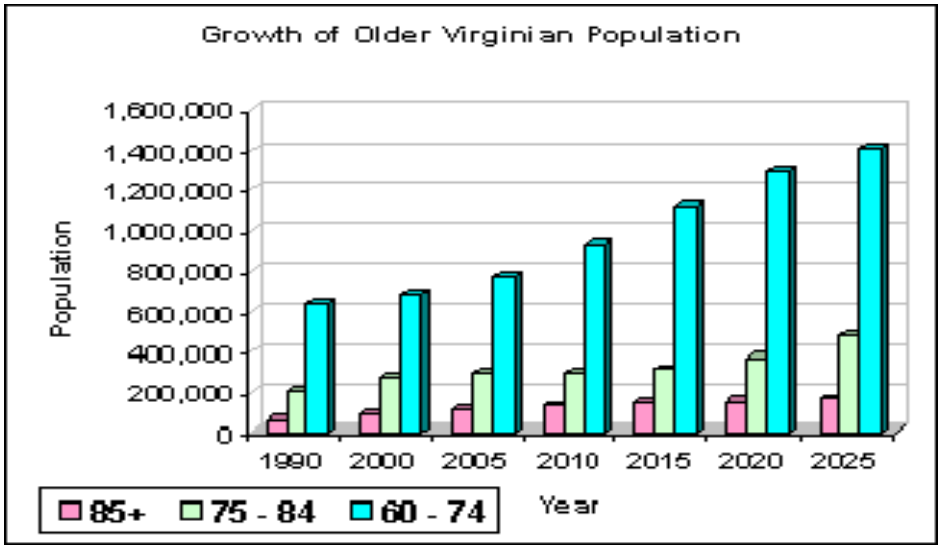
- The number of Virginians age 85 and older will increase dramatically between 1990 and 2025 – five times faster than the state's total population growth.

- Virginia's older population is growing more racially and ethnically diverse, reflecting the growing racial and cultural diversity of the Commonwealth and the nation. In 1990, older women outnumbered older men in Virginia by almost 42 percent. As a result of improving survival rates and increased life expectancies for older men, by 2025 older Virginian women are expected to outnumber older men by only 18 percent.

- The percentage of older Virginians that are married declines with age, with six times as many widows as widowers.

- In 1998, 42.8 percent of Virginians age 65 and over reported their health as "very good" to "excellent," surpassing the national average of 38.4 percent.

- Among Virginians age 60 and over in 1990, almost 90 percent had no self-reported limitations in mobility or self-care. Family members, friends and neighbors provide 80 percent of the long-term care of older Virginians living at home and needing some assistance.



Source: Virginia Department for the Aging.

Long-term care is not just about the elderly. Almost half of long-term care spending nationally is for the elderly, while the remainder is spent on individuals with disabilities. Increased number of individuals with developmental disabilities will create unique service delivery challenges in the coming years.

Unmet need is a critical issue for personal assistance services users. Researchers at the Disability Statistics Center at the University of California/San Francisco presented results of a recent national study that shows that unmet need is highly associated with numerous adverse consequences including falls, injuries, dehydration, weight loss, burns, and other problems that can worsen health and disability. The study determines how many hours of help are lacking among persons needing personal assistance with unmet need and demonstrates that additional public expenditures can help ease this problem. The lack in hours of needed personal assistance service is greatest for people who need help with two or more ADLs. Among these individuals, those with unmet need have an average shortfall of 16.6 hours of help per week, compared to those whose needs are met. The shortfall in needed hours of help is twice as great for people who live alone as for people who live with others. Among people with unmet need, those who live alone are more likely to experience adverse consequences than people who live with others, but both groups fare worse than those whose needs are met.

Medicaid benefits offering home- and community-based service alternatives are growing across the states. When home health is also counted as a home- and community-based care, the number of participants approximates the number of people who receive institutional placement in either a nursing facility or ICF/MR.

In terms of total expenditures and expenditures per participant, Medicaid home- and community-based services still are less costly than Medicaid institutional care. To some extent, such services may be the more economical long-term care alternative because they do not require board and care costs. Alternatively, the lower costs could be evidence that the states do not provide sufficient funding for these HCBS programs. For example, the average annual spending on a Medicaid personal care participant was just $6,870 (UCSF study). Increasing political pressures from disability advocates and legal precedents (e.g., the U.S. Supreme Court ruling in Olmstead v. L.C., (199 S. Ct. 2176, 1999), which requires states to offer appropriate alternatives to institutional placement when reasonably possible) are currently directing a great deal of attention on the future of these programs.

Data for this report were obtained from:

- *"The Virginia Medicaid Program at a Glance," January 2006.*
- *CMS 372 Reports, FY 2005.*
- *Statistical Record of the Virginia Medicaid Program, 2005.*
- *Alpha Listings from First Health Services and WVMI.*
- *Virginia Department for the Aging website.*
- *Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services.*
- *Internal SAS runs on the Assessment Data Base and data spreadsheets.*
- *Disability Statistics Center at the University of San Francisco.*
- *Virginia Joint Legislative Audit and Review Commission.*